



*Kelley Counseling*  
**Kelley Counseling PLLC**  
1145-D Executive Circle  
Cary, NC 27511  
919-249-5423

## Client Information Form

Date \_\_\_\_\_

DOB: \_\_\_\_\_

Client Name: \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email address: \_\_\_\_\_

Phone : (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

If under 18 years of age:  
Guardian Names/ Contact # / Relationship

\_\_\_\_\_  
\_\_\_\_\_

### Insurance Information (if self-pay client please omit)

Provider: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

Phone for Provider \_\_\_\_\_

Employer or School: \_\_\_\_\_  
Name Phone Number

Primary Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medications or Supplements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact (Name/#): \_\_\_\_\_

What do I want out of therapy and or what are my goals?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any requests and or preferences (i.e. time of appointment, certain treatments to try or avoid, people you wish to include in your treatment):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I look forward to working with you to improve on these goals!*